APPLICATION FOR INITIAL CLINICAL PRIVILEGES AND STAFF APPOINTMENT

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.

Principal Purpose: To document the provider's professional qualifications as the basis for clinical privileges and staff appointment.

Routine Uses: To support the credentialing and privileging processes. A copy of this form will be retained in provider credentials file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your clinical privileges or professional staff appointment.

INSTRUCTIONS. This form is to be completed by all providers (military/civilian) who are first time applicants for clinical privileges and for *initial* medical staff appointment, if requested. Initial staff appointment is granted on the occasion of the provider's first assignment/ employment at a DoD MTF, or if there has been a lapse in DoD MTF appointment status of greater than 180 days, e.g., the provider has been involved in civilian training program.

SECTION I - IDENTIFICATION

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSAN	4. DATE OF BIRTH *(YYYYMMDD)*

5. SPECIALTY/AOC	6. MEDICAL/DENTAL FACILITY *(Name and Address: City/State/Zip Code)*
	RAYMOND W. BLISS ARMY HEALTH CENTER, FORT HUACHUCA, AZ 85613-7040

SECTION II - PROFESSIONAL EDUCATION

7a. COLLEGE OR UNIVERSITY	7b. LOCATION *(City/State)*	7c. DEGREE	7d. GRADUATION DATE *(YYYYMMDD)*

SECTION III - POSTGRADUATE TRAINING

8a. HOSPITAL OR INSTITUTION	8b. LOCATION *(City/State)*	8c. PROGRAM *(Residency, etc.)*	8d. COMPLETION DATE *(YYYYMMDD)*

SECTION IV - PREVIOUS PROFESSIONAL AFFILIATIONS *(Past 10 years. Continue on reverse in block 23.)*

9a. HOSPITAL OR INSTITUTION	9b. LOCATION *(City/State)*	9c. FROM/TO *(YY/MM-YY/MM)*	9d. DEPARTMENT

SECTION V - BOARD CERTIFICATION/PROFESSIONAL SOCIETY MEMBERSHIP

10. Are you eligible to take your board examination? ☐ N/A ☐ NO ☐ YES *(If YES, indicate specialty in block 22.)*

11. Have you taken your boards? ☐ NO ☐ YES *(If YES, note date.)* _____ ☐ TOTAL ☐ PARTIAL

12. Are you ABMS board certified? ☐ NO ☐ YES *(If YES, indicate specialty in block 23.)*

13. Memberships in Specialty Societies. *(List all active memberships.)*

SECTION VI - LICENSURE/CERTIFICATION/REGISTRATION. *(Include all current and previous states of licensure.)*		
14a. STATE OR AUTHORIZING AGENCY	14b. LICENSE NUMBER	14c. EXPIRATION DATE *(YYYYMMDD)*

SECTION VII - CONTROLLED SUBSTANCES REGISTRY		
15a. DEA OR CDS NUMBER	15b. STATE OF ISSUE *(If applicable)*	15c. EXPIRATION DATE *(YYYYMMDD)*

SECTION VIII - CLINICAL PRIVILEGES REQUESTED

16. I attest that based on my professional qualifications and credentials, I am clinically competent to fully perform the clinical privileges for which I am applying. I request privileges in the following disciplines:

17. I request privileges in the following category: *(Check one.)*
☐ Regular ☐ Temporary ☐ Supervised

18. I request admitting privileges.
☐ YES ☐ NO

19. I request to manage and treat patients in age groups: *(Check all that apply.)*
☐ Neonates (Birth - 28 days) ☐ Infants (1-24 mos) ☐ Children (2-12 yrs) ☐ Adolescents (13-17 yrs) ☐ Young Adults (18-23 yrs) ☐ Adults (24-65 yrs) ☐ Geriatrics (> 65 yrs)

SECTION IX - STAFF APPOINTMENT REQUESTED

20. I request initial appointment to the medical/dental staff of this health care facility. ☐ YES ☐ NO

SECTION X - OTHER

21. Do you possess ECFMG certification? ☐ N/A ☐ NO ☐ YES *(If YES, note date of issue.)* _____

22. Which of the following do you possess? *(Check all that apply.)* ☐ BLS ☐ ACLS ☐ ATLS ☐ PALS ☐ Other *(specify)* _____

SECTION XI - COMMENTS

23. Provide explanation or additional details for any of the numbered items above. *(Note item number.)*

24. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge.

	24a. SIGNATURE OF PROVIDER	24b. DATE *(YYYYMMDD)*

APPLICATION FOR RENEWAL OF CLINICAL PRIVILEGES AND STAFF APPOINTMENT

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.

Principal Purpose: To document the provider's professional qualifications as the basis for clinical privileges and staff appointment.

Routine Uses: To support the credentialing and privileging processes. A copy of this form will be retained in provider credentials file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your clinical privileges or professional staff appointment.

INSTRUCTIONS. This form is to be completed by all providers (military/civilian) who are requesting renewal of clinical privileges and/or reappointment to the medical/dental staff. The information provided herein is to update that contained on DA Form 4691.

SECTION I - IDENTIFICATION

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSAN	4. DATE OF BIRTH *(YYYYMMDD)*

5. SPECIALTY/AOC	6. MEDICAL/DENTAL FACILITY *(Name and Address: City/State/ZIP Code)*
	RAYMOND W. BLISS ARMY HEALTH CENTER, FORT HUACHUCA, AZ 85613-7040

SECTION II - PROFESSIONAL EDUCATION

7. EDUCATIONAL DATA.
List residency training, fellowships, any formal schools attended, etc., **since your previous application for privileges.**

7a. INSTITUTION	7b. ADDRESS *(City/State)*	7c. PROGRAM	7d. FROM/TO *(YYMM-YYMM)*

8. BOARD STATUS.
Have you passed a professional specialty board or re-boarded **since your previous application for privileges?** ☐ NO ☐ YES ☐ N/A

8a. DATE TAKEN *(YYYYMMDD)*	8b. SPECIALTY BOARD	8c. EXPIRATION DATE *(YYYYMMDD)*

9. CERTIFICATION DATA.
Have you passed a professional specialty certification examination **since your previous application for privileges?** ☐ NO ☐ YES

9a. DATE TAKEN *(YYYYMMDD)*	9b. CERTIFYING ORGANIZATION	9c. EXPIRATION DATE *(YYYYMMDD)*

10. CONTINUING EDUCATION.
Total hours of CME/CDE or other professional education attended **since your previous application for privileges** _____ .

11. CURRENT PROFESSIONAL ASSOCIATIONS. *(Indicate memberships.)*	12. CURRENT TEACHING APPOINTMENTS. *(Note appointments or positions.)*

13. OTHER PROFESSIONAL RECOGNITION. *(Please specify recognition received since your last application for privileges.)*

SECTION III - LICENSURE/CERTIFICATION/REGISTRATION

14a. STATE LICENSING/AUTHORIZING AGENCY	14b. NUMBER	14c. EXPIRATION DATE *(YYYYMMDD)*

15a. DEA/CDS REGISTRATION *(Specify state as applicable.)*	15b. NUMBER	15c. EXPIRATION DATE *(YYYYMMDD)*

16a. CERTIFICATION	16b. ISSUED BY	16c. EXPIRATION DATE *(YYYYMMDD)*
BLS		
ACLS		
ATLS		

SECTION IV - CLINICAL PRIVILEGES REQUESTED

17. I attest that based on my professional qualifications and credentials, I am clinically competent to fully perform the clinical privileges for which I am applying. I request renewal of my clinical privileges as specified on attached DA Form 5440-series appropriate to my discipline.
Type of privileges requested: ☐ Regular ☐ Temporary ☐ Supervised

18. I request reappointment to the medical/dental staff in the following category:
☐ Active ☐ Affiliate ☐ Temporary ☐ No Appointment

19. I request admitting privileges.
☐ YES ☐ NO

20. I request to manage and treat patients in age groups: *(Check all that apply.)* ☐ Neonates (Birth - 28 days) ☐ Infants (1-24 mos)
☐ Children (2-12 yrs) ☐ Adolescents (13-17 yrs) ☐ Young Adults (18-23 yrs) ☐ Adults (24-65 yrs) ☐ Geriatrics (> 65 yrs)

SECTION V - COMMENTS

21. Provide explanation or additional details for any of the numbered items above. *(Note item number.)*

22. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge.

	22a. SIGNATURE OF PROVIDER	22b. DATE *(YYYYMMDD)*

APPROVAL OF CLINICAL PRIVILEGES/STAFF APPOINTMENT

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSAN	4. EFFECTIVE PERIOD *(YYYYMMDD)* FROM TO

5. PRIVILEGES REQUESTED. *(Specify discipline(s))*

☐	a. Aerospace medicine	☐	k. Neurology	☐	u. Physician assistant
☐	b. Anesthesia	☐	l. Nurse anesthesia	☐	v. Podiatry
☐	c. Audiology	☐	m. Nurse midwifery	☐	w. Psychiatry
☐	d. Chiropractic	☐	n. Nurse practitioner	☐	x. Psychology
☐	e. Clinical pharmacy	☐	o. Obstetrics and gynecology	☐	y. Radiology/Nuclear medicine
☐	f. Dentistry	☐	p. Occupational therapy	☐	z. Social work
☐	g. Dietetics	☐	q. Optometry	☐	aa. Speech pathology
☐	h. Emergency medicine	☐	r. Pathology	☐	ab. Surgery
☐	i. Family practice	☐	s. Pediatrics	☐	ac. Other (specify)
☐	j. Internal medicine	☐	t. Physical therapy	☐	

6. RECOMMENDATIONS. The following department/service and credentials committee recommendations are based on a review of the provider's verified licensure, education and training, experience, physical and mental capabilities to perform the requested privileges and demonstrated current competence. Exceptions or stipulations are noted below in block 7.

a. MEDICAL TREATMENT FACILITY/DENTAC *(Name and location)*	b. APPOINTMENT STATUS	c. CATEGORY OF PRIVILEGES
RAYMOND W. BLISS ARMY HEALTH CENTER FORT HUACHUCA, AZ 85613-7040	☐ Initial ☐ None ☐ Active ☐ Affiliate ☐ Temporary	☐ Regular ☐ Supervised ☐ Temporary

d. ADMITTING PRIVILEGES	e. PLAN OF SUPERVISION	f. NAME OF SUPERVISOR *(If applicable)*
☐ Requested ☐ Granted ☐ Not requested ☐ Not granted	☐ Required ☐ Not required	

g. AGE GROUPS: *(Check all that apply.)* ☐ Neonates (Birth - 28 days) ☐ Infants (1-24 mos) ☐ Children (2-12 yrs) ☐ Adolescents (13-17 yrs) ☐ Young Adults (18-23 yrs) ☐ Adults (24-65 yrs) ☐ Geriatrics (> 65 yrs)

h. DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	i. SIGNATURE	j. DATE *(YYYYMMDD)*

k. The credentials committee met on _____ to review the merits of this provider's application for staff appointment and/or clinical privileges. It is the decision of this committee to ☐ CONCUR ☐ NOT CONCUR with the above recommendations. Exceptions or stipulations are noted below in block 7.

l. CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	m. SIGNATURE	n. DATE *(YYYYMMDD)*
WILLIAM T. HUMPHREY JR., LTC, MC DCCS/CHAIRMAN		

7. REMARKS

8. The Executive Committee of the Medical/Dental Staff (ECMS/ECDS) reviewed this provider's request for privileges and medical staff appointment, as applicable, on _____ . It is the decision of this committee to ☐ CONCUR ☐ NOT CONCUR with the above recommendations.

8a. ECMS/ECDS CHAIRPERSON *(Name and rank)*	8b. SIGNATURE	8c. DATE *(YYYYMMDD)*
WILLIAM T. HUMPHREY JR., LTC, MC DCCS/CHAIRMAN		

9. APPROVAL. Based on my review of the information submitted in support of the provider's licensure, education and training, and his/her demonstrated competence, privileges are approved and medical staff membership is awarded as requested. The period for which clinical privileges and staff membership are in effect is as noted above in Block 4.

9a. NAME OF HOSPITAL/DENTAC COMMANDER	9b. COMMANDER'S SIGNATURE	9c. DATE *(YYYYMMDD)*
THOMAS W. SMITH, COL, MC COMMANDER		

MALPRACTICE HISTORY AND CLINICAL PRIVILEGES QUESTIONNAIRE

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority:	Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.
Principal Purpose:	To document the provider's professional qualifications as the basis for clinical privileges and staff appointment.
Routine Uses:	To support the credentialing and privileging processes. A copy of this form will be retained in provider credentials file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.
Disclosure:	Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your clinical privileges or professional staff appointment.

INSTRUCTIONS. This form is to be completed by all health care providers (military/civilian) upon initial entry or re-entry into Federal Service, and as part of the periodic clinical privileges renewal process.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSAN	4. DATE OF BIRTH *(YYYYMMDD)*

5. SPECIALTY/AOC	6. MEDICAL/DENTAL FACILITY *(Name and Address: City/State/Zip Code)*
	RAYMOND W. BLISS ARMY HEALTH CENTER, FORT HUACHUCA, AZ 85613-7040

7. Place a check (X) in the column that corresponds to your answer to each of the following questions. *(Any "YES" answer must be fully explained on the bottom of this page in block 8.)* Note: An answer is required for every question.

INITIAL

YES	NO	ARE YOU NOW OR HAVE YOU EVER:
		a. Been required to appear before any medical or State regulating authority, regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted provider?
		b. Had a history of alcohol or other drug abuse or misuse?
		c. Had your narcotics registration suspended or revoked?
		d. Had your professional privileges voluntarily or involuntarily denied, revoked, suspended, reduced, or restricted by a health care facility?
		e. Had your request for any specific clinical privilege(s) denied or granted with specific limitations?
		f. Voluntarily or involuntarily resigned or otherwise disassociated yourself from employment or practice after being notified of the intent to initiate action against you for failure to properly execute your professional responsibilities?
		g. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional, or substandard professional practice?
		h. Had your professional license voluntarily or involuntarily denied, restricted, withdrawn, suspended, or revoked by a State or local licensing board or other authority?
		i. Been asked to voluntarily surrender your license?
		j. Had a previously successful or currently pending challenge(s) to any license or registration (e.g., State or District, Drug Enforcement Agency, etc.) that you hold now, or have held?
		k. Been refused membership in an institution's medical or dental staff?
		l. Been denied membership, or renewal thereof, or been subject to disciplinary action in any medical/dental organization?
		m. Been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance programs (i.e., Medicare or Medicaid)?
		n. Had your professional liability coverage canceled, limited, denied, or not renewed?

8. COMMENTS. Note item by number (7a. - 7n.) and provide clarification of any question with a "YES" answer. Include clarification for any circumstance not already addressed in detail on a previous DA Form 5754. *(Continue on a separate page.)*

9. HEALTH STATUS. Provide a brief description of your current physical and mental health status and your ability to perform the clinical privileges appropriate to your discipline.

10. MALPRACTICE INSURANCE. Initial applicants address past 10 years, all others list only current carriers.

10a. CARRIER *(Current and previous)*	10b. ADDRESS *(Street/City/State/ZIP Code)*	10c. POLICY NUMBER

11. CLINICAL PRIVILEGES. Initial applicants address past 10 years, all others list the hospitals/institutions where privileges are currently held.

11a. HOSPITAL/INSTITUTION	11b. ADDRESS *(Street/City/State/ZIP Code)*	11c. FROM/TO *(YYMM-YYMM)*

12. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge. I hereby authorize the U.S. Army to contact the malpractice carriers and the hospitals/institutions listed above for the purpose of verifying the information provided.

	12a. SIGNATURE OF PROVIDER	12b. DATE *(YYYYMMDD)*

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT HUACHUCA, ARIZONA 85613-7040

REPLY TO
ATTENTION OF

MCXJ-PI

MEMORANDUM FOR RECORD (CREDENTIALS FILE)

Subject: Healthcare Providers - Statement of Health

Initial under the correct response to each question.	Yes	No
1. Do you have any physical condition/impairments of a chronic or recurring nature that is debilitating or requires the use of medication?		
2. Have you ever been diagnosed as having any mental illness or substance abuse disorder?		
3. Have you ever received any counseling/treatment for a mental health condition or substance abuse?		
4. Are you currently or have you ever been treated with psychiatric medication? (Anxiolytics, anti-depressants, anti-psychotics)		
5. Do you have a physical or mental condition(s)/impairments(s) that might interfere with your ability to practice medicine within the scope of privileges for which you have applied?		

INITIAL

Explanations required when a response to any question above is positive.
Comments:

_____
Date

_____
Signature, «Grade» «FirstName» «LastName»

I have personally discussed the physical and mental status of the above with him/her.

_____
Chief, Dept/Svc

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT HUACHUCA, ARIZONA 85613-7040

REPLY TO
ATTENTION OF

STATEMENT OF APPLICANT
(Please read carefully before signing)

All information submitted by me in this application is true to my best knowledge and belief. I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff.

In making this application for appointment to the medical staff of this health center, I acknowledge my obligation to provide continuous care and supervision of my patients, to accept committee assignments, to accept consultation assignments and to participate in additional staffing requirements.

By applying for appointment to the medical staff I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize the health center, its medical staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated, and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the health center, its medical staff and its representatives of all documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as, my moral and ethical qualifications for staff membership.

I hereby, release from liability all representatives of the health center and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the health center, or its medical staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize the health center to communicate to other hospitals and to other persons or organizations with a legitimate interest therein any information concerning my professional competence, character and ethics that the hospital may have or acquire, and where such communication is made in good faith and without malice, and I consent thereto to agree to hold the health center and its authorized representatives free of liability therefor.

I understand and agree that I, as an applicant for medical staff membership or privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I particularly agree to subject my clinical performance to, and faithfully participate in, the health center's quality assurance programs as the same shall from time to time be in effect, and I agree to hold members of the medical staff and other authorized representatives of the hospital engaged in these quality assurance activities free of all liability for their actions performed in good faith in connection therewith.

DATE

SIGNATURE OF APPLICANT